

MHIT Overview Nov 2020.docx

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LAPD COMPREHENSIVE TRAINING PLAN MENTAL ILLNESS

November 2, 2020

BRIEFING NOTES for Command Staff
Prepared by the Mental Evaluation Unit

Mental Evaluation Unit (MEU) Administrative-Training Detail

The Administrative Training Detail is responsible for conducting the 40-hour Mental Health Intervention Training (MHIT), which is delivered every other week. The Detail is also responsible for addressing mental health-related topics during training for Field Training Officers (FTO), Police Service Representatives (911 operators), Security Services (security for Los Angeles City facilities) and Adult Custody Officers (jail personnel).

SOURCE DOCUMENTS

- Standard Roll Call Training Program, Deployment Period #10-05, "Suicide by Cop Indicators"
- Standard Roll Call Training Program, Deployment Period #10-05, "Suicide by Cop Tactical Considerations"
- Standard Roll Call Training Program, Deployment Period #3-06, "8102(a) WIC-Weapons Confiscation"
- Standard Roll Call Training Program, Deployment Period #10-06, "5150.05 WIC-Mental Health History"
- UOFRD, Roll Call Briefing Sheet, June 3, 2013, "Mental Illness Contacts"
- Chief of Detectives Notice, January 17, 2014, "Duty to Preserve Property of a Person Taken into Custody for a MH Evaluation"
- Chief of Detectives Notice, July 21, 2015, "Implementation of Laura's Law"
- PTB Notice, May 1, 2014, "Mental Health Update Training Requirement"
- OCOP Special Order No. 6, March 16, 2016, "Manual sections revised, Field Notebook Divider, Release of Firearm Advisement Form."
- OO, Operations Order No. 5, June 3, 2016, "MHIT Training Requirement for Sworn Personnel assigned to Homeless Outreach Programs"
- OO Notice, December 28, 2017, "NAMI Initiative"
- Chief of Detectives Notice, January 18, 2018, "Providing Alternatives to Hinder Extremism (PATHE) Risk Assessment and Management Strategy/CAMP Investigative Entity"
- OCOP Notice, July 27, 2018, "LAPD Inmate Classification Screening Form"
- Roll Call Training Update, September 2016, "Transport Request of a Person with Mental Illness from a Hospital"
- UOF-Tactics, Directive No. 16, October 2016, Tactical De-escalation Techniques"
- Chief of Detectives Notice, November 18, 2016, "Gun Violence Restraining Orders"
- Chief of Detectives Notice, May 19, 2017, "Determination of Persons Suspected from Suffering from Mental Illness"
- Chief of Detectives Notice, November 19, 2018, "Apprehension and Transportation Orders"
- OO Notice, March 29, 2019, "MEU Contact Disposition Codes on DFAR"

ONGOING TRAINING

- MHIT (Police Sciences & Leadership 1 [PSL 1] and Inservice Classes)—**40 hour**
- Crisis Intervention MHIT—**8 hour**
 - FTO Compliance (Senate Bill 29)
 - Security Services Division (SECSD)
 - Custody Services Division (CSD)
 - LA Bureau of Sanitation, Watershed Protection Division(WPD)
 - Los Angeles County Probation (Juvenile Camp) – 8/22/2019
- FTO School—**4 hour**
- FTO School Update—**2 hour**
 - NOTE: Previous 4-hour course changed to 2 hours per Field Training Section's request (legal and policy updates)
- Supervisor School—**2 hour**
 - Systemwide Mental Assessment Response Team (SMART) Supervisors (Operations, Policy and Procedure)
- Emergency Broadcast Operator (EBO) School—**2 hour**
- CSD Academy—**8 hour**

ONLINE TRAINING

- National Alliance on Mental Illness (NAMI) Video (LMS) December 28, 2017
- Roll Call Training Series—seven (7) blocks of training with questions & answers
- POST Mental Health Update video—**2 hour** (since 2016; update in progress)

COMMAND STAFF

Recommendations:

- Provide briefings on training strategies at all CO meetings
- Provide a block of instruction at Command and Development School

RECENT PUBLICATIONS

- FTO Manual (MHIT Requirement)
- OCOP Special Order No. 6, March 16, 2016 (update in approval process)
- Homeless Outreach Program Personnel MHIT requirement (Operations Order No. 5, June 3, 2016)
- Targeted Violence Community Reference Guide (Chief of Detectives Notice, October 27, 2020)
- Patient Dumping (Chief of Detectives Notice, May 14, 2020)

TRAINING BULLETINS

- **Tactical Disengagement**, Volume XLVIII, Issue 5, July 2019
- **Developmental Disabilities**, Volume XL, Issue 1, October 2018
- **Barricaded Suspects**, Volume XLV, Issue 4, December 2016
- **Excited Delirium**, Volume XLVIII, Issue 3, December 2016
- **Handcuffing**, Volume XLVIII, Issue 6, August 2019

SPECIALIZED TRAINING DESCRIPTION AND STATISTICS

MHIT (40 hour)

Provides patrol officers with best practices in dealing with persons suspected of suffering from mental illness. This course incorporates an interactive adult learning model which is taught by LAPD officers and Department of Mental Health (DMH) clinicians, that includes field trips to community service providers, small group activities, case studies, and presentations with community members with mental illness, as well as family members with lived experiences.

First Delivery: June 2014

Course Deliveries through October 2020: 139

Total Students Trained through October 23, 2020: 4217

Outside Agencies Trained (DMH civilians, LAPD civilians, Federal Officers, LAFD Arson and Medics, Military): **407**

LAPD Totals: 3810

PSL Totals: 1695

CRISIS INTERVENTION MHIT (8 hour)

This is a condensed course derived from the 40-hour MHIT, which provides a basic mental health training model that MEU uses as a framework to provide training to City entities/partners.

- **FTO Compliance (8 hour)**

Provides patrol officers with best practices in dealing with persons suspected of suffering from mental illness. This course incorporates an interactive adult learning model which is taught by LAPD officers and Department of Mental Health clinicians. It excludes field trips to community service providers and student presentations.

Total Students Trained: 428 from 2016-present

NOTE: The delivery of this course resulted in the Department's compliance with FTO training and a State reimbursement to the City of Los Angeles in the amount of **\$545,424**.

- **SECSO (8 hour)**
Provides police officers and unarmed/private security personnel with training to assess situations involving persons at Los Angeles City facilities who may be suffering from mental illness and may meet the 5150 Welfare and Institutions Code (WIC) criteria.

Total Students Trained: 51 from 2018 through 2019

- **CSD (8 hour)**
Provides detention officers with training to assess situations involving persons who are in a jail environment suffering from mental illness and may meet the 5150 WIC criteria. The assessment may necessitate segregation, transfer, or release on their own recognizance with a referral to the appropriate mental health care resource.

NOTE: CSD maintains statistics on the total number of students trained.

Total Students Trained: 389 from 2018 through 2019

- **Bureau of Sanitation, Watershed Protection Division (WPD) (8 hour)**
Provides environmental compliance officers with training to assess situations involving persons who may be suffering from mental illness and may meet the 5150 Welfare and Institutions Code (WIC) criteria.

Total Students Trained: 58

- **EBO School (2 hour)**
Provides dispatchers with current information related to understanding a person with mental illness and how to effectively triage calls for service.

NOTE: Communications Division maintains statistics on the total number of students trained. Since 2018, MEU has provided **eight course deliveries** at EBO Academies. In August 2020, Communications Division reduced the MEU block of instruction to one hour.

Total Students Trained in 2020: 20

- **CSD Academy (4 hour)**
Provides CSD new hires with training to assess situations involving persons who may be suffering from mental illness and may meet the 5150 WIC criteria.

Total Students Trained: 21

- **Probation (8 hours)**
Provides Los Angeles County Probation Officers with training to assess situations involving persons who may be suffering from mental illness and may meet the 5150 Welfare and Institutions Code (WIC) criteria.

Total Trained: 41

- **CARE** (Cleaning and Rapid Engagement) (4 hours)
This was a direct ask from Mayor Garcetti's office to support his initiative to disengage police and train LASAN and LAHSA personnel on best practices in dealing with persons suspected of suffering from mental illness.

Total Trained in September 2019: 262

ROLL CALL TRAINING

- Roll call training is provided on an ongoing basis by MEU SMART officers and MEU SLOs on dealing with the assessment, evaluation and transportation of mentally ill subjects.

In 2019:

- SMART conducted **145** roll call trainings, with **1090** officers trained
- SLOs conducted **217** roll call trainings, with **2859** officers trained
- The Guidance Center partnered with the Department to develop a series of web-based trainings for any local or state law enforcement agency across the country to use at no cost. The training series received a Bronze Award in the 40th Annual Telly Awards and was delivered as part of the Department's standardized roll call training from **DP 5 through DP 12, 2019**.

COMMUNITY IMPACT

On May 11, 2020, the MEU received an email from Brittney Weissman, Chief Executive Officer of the National Alliance on Mental Illness (NAMI), Greater Los Angeles County, who advised that they had received a phone call from someone over the weekend who had called 911 for a mental health crisis involving his girlfriend. The caller had nothing but good things to say about his experience with LAPD and the positive outcome. He also shared that he had been connected to NAMI because of referral information that LAPD had provided at MHIT (referral contact information is provided in English, Spanish, and Korean). Weissman wanted to give kudos to the Department for the handoff to NAMI, who was a longer-term solution for the caller.

On June 3, 2020, the Mayor's Office announced that the Department would enhance police training, expanding MHIT to train 900 officers in 2020, from 700 in 2019. As of October 23, 2020, 693 officers have been trained and we are 77% closer to the Department's 900-officer goal.

As of November 2020, we are tracking a dramatic increase in crisis calls. There has been a **16% weekly** increase and a **26% increase** yearly increase in calls, with **80%** of crisis calls being handled by a MHIT-trained officer.



TRAINING BULLETIN

Los Angeles Police Department

Michel R. Moore, Chief of Police

Volume XLIX, Issue 7

June 2020

HANDCUFFING

The principle reason for handcuffing is to maintain control of an individual and to minimize the possibility of a situation escalating to a point that would necessitate using a higher level of force or restraint. The decision to use restraining procedures and devices depends on common sense and good judgment. While felony arrestees shall normally be handcuffed, the restraining of detainees and misdemeanants is discretionary. The purpose of this Bulletin is to examine discretion and safety considerations in handcuffing.

Discretion in Handcuffing

The decision to handcuff a person is not based on rigid criteria. It is determined by the nature of each situation as perceived by the officer. To ensure the effective and appropriate use of handcuffs, it is necessary to place the responsibility for handcuffing with the involved officers. Officers should evaluate all available facts and circumstances concerning each person prior to determining whether or not to use handcuffs. The varied nature of each situation makes it unrealistic to provide specific and detailed guidelines for handcuffing.

When determining whether or not to handcuff a person, the following factors should be considered: the possibility of escape or the incident escalating, the potential threat to the officers and other persons, the positional advantage or disadvantage of the officer during searching procedures, the size, relative strength, and skill level of the officer versus the person, and the knowledge of the individual's previous encounters with law enforcement.

People with Mental Illness: Officers shall handcuff a person with mental illness taken into custody when the person is not restrained by means of a straitjacket or restraining straps. Officers may refrain from handcuffing if the person with mental illness has a physical impairment or other medical condition such that handcuffing is not feasible or appropriate, and the safety of others is not jeopardized.

Safety Considerations

Handcuffs are meant to be a temporary restraint and are not escape-proof. Officers should always remain alert for an attempted escape. It is not uncommon for a person to conceal a handcuff key or metal shim to assist in escaping from custody. Additionally, people may attempt to slip the handcuffs off their hands, or underneath their legs. Officers should also be aware that some people may be able to remove weapons from their front or rear waistband area and pants pockets even while handcuffed. Officers should not assume that handcuffing removes the possibility of the person using a weapon against them. Officers should continue to monitor the individual after being handcuffed, including during transportation, while at a hospital for medical treatment and while an arrestee is in a holding tank prior to booking. Remember that an arrestee who is seated on a holding bench should be properly handcuffed and secured to the bench.

Injuries

While minor injuries such as abrasions and contusions are sometimes unavoidable even when the handcuffs are properly applied, officers should attempt to minimize more serious injuries by checking to ensure the handcuffs are not too tight. The handcuffs should be just loose enough that they do not cut off the circulation. If the handcuffs are so tight that they cannot slide on the skin at all, they may be too tight. Conversely, the handcuffs should not be so loose that they can slide over the protruding bone of the wrist in either direction. If the handcuffs are too loose, the person may be able to escape by slipping the handcuffs over their hands; some people can make the diameter of their hand smaller than their wrist bone. The handcuffs shall be double locked prior to transportation to ensure that they do not tighten inadvertently.

Handcuffing Techniques

Handcuffing techniques include speed cuffing, handcuffing with the hands behind the head, handcuffing from the high risk prone and high risk kneeling positions, handcuffing from a rear arm finger flex, and handcuffing on the ground from the back-control position. The specific technical procedures for each of these techniques can be found in the LAPD Arrest and Control Manual.

Basic Handcuffing Procedures: When there is a need to use handcuffs, officers should remember the basic procedures for proper application. The hands should be handcuffed behind the back with palms together, or back-to-back. Attempt to avoid injury to the wrists when applying the handcuffs and check to ensure the handcuffs are not too loose or too tight. Handcuffs should be double-locked.



Speedcuffing: An effective way to quickly secure a person's hands. With the person in the pat down position, the handcuffs are drawn and held by the chain. The handcuffs are pressed onto one wrists, then onto the other wrist in one fast, crisp motion. The handcuffs are immediately adjusted to firmly secure the hands.



Plastic Handcuffs: The plastic handcuff is a disposable restraining device provided to officers for use as an alternate or reserve means of restraint. Officers should carry two of these handcuffs as part of their field equipment. This will allow the control and transportation of arrestees when there are not enough steel handcuffs available.

The plastic handcuff is prepared for use by inserting the serrated tips of the straps through the eyelets located between the two straps, forming two loops. The person's hands should be placed behind the back, palms out, with the thumbs up. The cuffs are placed over hands and tightened to secure the wrists. The one-way locking action in the head of the plastic handcuff prevents the restraint from being loosened once applied. Therefore, care should be taken not to tighten the restraint more than is necessary. The restraint is removed by using Department cutters which are available in the Area watch commander's offices and in some supervisors' vehicles.



Plastic handcuffs should not be used to restrain combative persons or persons with mental illness. These restraints can be difficult to apply while attempting to gain physical control of a person. Additionally, if a person continues to struggle and resist these restraints once they have been applied, it may cause abrasions or contusions to their wrists.

When two people have been handcuffed, they may be secured together by using a plastic handcuff around their upper arms. One loop of the plastic handcuff is secured on the first person's upper arm, and the other loop secures the second individual's upper arm.



The plastic handcuff can also assist officers in controlling an already handcuffed person by preventing them from slipping the handcuffs underneath their legs. The person's handcuffed hands can be secured to the belt by utilizing a plastic handcuff looped around the handcuffs' linking chain and belt.



When a person is in custody at a Non-Secure Contract Hospital, and an MRI or CT Scan procedure is needed, officers will need to remove Department issued handcuffs, due to the prohibition of metallic objects during these procedures. Plastic cuffs should be used to replace handcuffs for officer safety during the scan. Handcuffs should not be removed until the plastic cuffs have been applied. Once the medical procedure is complete, the handcuffs should be placed back on before removing the plastic cuffs.

Hobble Restraint Device: The Hobble Restraint Device may be used as an alternative to handcuffs on a non-violent person with an arm injury or full arm cast. The officer places the hobble loop just above the elbows. The loop is slowly tightened until it appears the person cannot escape.



This technique can also be used for removing handcuffs from a violent person for fingerprinting, medical treatment, or to place the person into a holding cell with a minimal chance for an altercation. While the person is still handcuffed, the officer places the hobble loop just above the elbows. The loop is slowly tightened until it appears the person cannot escape. The officer can now safely remove the cuffs for medical treatment or fingerprinting. Additionally, if the officer intends to place the person into a cell, this method allows control of the person at the elbows. The officer then directs the person into the cell. As the person moves forward into the cell, the officer releases the hobble and pulls it free from the person's arms.

The hobble can also assist officers in controlling already handcuffed people by preventing them from slipping the handcuffs underneath their legs. The hobble can be looped around the person's waist and clipped to the handcuffs' linking chain. After locking the hobble around the arrestee's waist, any excess must be wrapped around the handcuffs' linking chain or person's wrist before it is clipped to the handcuffs.





Carabiner Hook: The carabiner hook is a 2" x 3 ½" aluminum alloy device that has a safety locking mechanism. The primary use of the carabiner hook is to assist officers in controlling handcuffed people by preventing them from slipping the handcuffs underneath their legs.

To utilize the carabiner hook, twist open the safety lock. Press open the carabiner and hook it onto the handcuff chain. Attach the open end to the persons's belt or belt loop and twist the safety lock tightly closed to secure the hook. The carabiner hook is to be used only to control handcuffed persons as described above and must only be placed on the handcuffs and through the persons's belt or belt loop. Generally, the carabiner hook shall not be used as a striking weapon or as a tool for attaching suspects to other suspects, to fences, vehicles, or any other object.



Removal of Handcuffs from Gravely Injured Persons at the Request of the Los Angeles Fire Department or Other Medical Personnel: The use of handcuffs to control a person is meant to prevent a situation from escalating to where a higher level of force would be necessary. Situations may arise when an officer uses force to control a person, up to and including deadly force. The person may need immediate medical treatment, in an attempt to prevent the loss of human life. In such instances, the responding employees from the Los Angeles Fire Department, or other attending medical personnel, may request the removal of handcuffs from the person to render immediate medical treatment.

To adhere to the Los Angeles Police Department's guiding principle of Reverence for Human Life, officers should use good judgment and discretion, and if safe to do so, remove handcuffs from a gravely injured person to allow for immediate medical treatment. Prior to the removal of handcuffs, officers should ensure that the person does not have access to weapons that could harm medical personnel, officers or themselves. This can be achieved by a thorough search of the suspect and the surrounding area. Once the handcuffs are removed, the officers shall remain vigilant and maintain a position that will allow them to visually observe the person and intervene, if necessary, to prevent injury to all involved parties.

CONCLUSION

Officers must be aware of the Department's discretionary handcuffing policy and how this policy influences handcuffing and restraining people. Handcuffing is not based on rigid criteria. Rather, it is determined by the unique nature of each situation, the officer's evaluation of the incident, and a concern for the wellbeing of all involved persons. Even though a person is handcuffed, a high degree of vigilance is still required of the officers.

This Bulletin cancels and supersedes Volume XLVIII, Issue 6, Handcuffing, August 2019

Field Training Services Unit
Police Training and Education

DISTRIBUTION "A"



TRAINING BULLETIN

Los Angeles Police Department

Michel R. Moore, Chief of Police

Volume XLVIII, Issue 9

December 2019

BARRICADED SUSPECTS/SUBJECTS

Incidents involving a barricaded suspect/subject present significant safety concerns to first responders, the barricaded individual, and the community. To ensure the safety of all involved, these volatile situations often require police to utilize not only special equipment and tactical training, but specific expertise in crisis negotiation. The Department's Special Weapons and Tactics (SWAT) team along with its Crisis Negotiation Team (CNT) component is equipped and trained to resolve incidents that involve a barricaded suspect/subject.

The purpose of this Bulletin is to provide the incident commander (IC) and/or first responders with the information necessary to manage an incident that involves a barricaded suspect/subject.

What is a Barricaded Suspect?

A barricaded suspect incident prompting a SWAT response may include, but is not limited to the following criteria:

1. The suspect is probably armed; **and**
2. Probable cause exists to believe that the suspect has been involved in a criminal act **or** is a threat to the lives and safety of the community and/or police; **and**
3. Is in a position of advantage, affording cover and/or concealment; **or** is contained in an open area and the presence or approach of police officers could precipitate an adverse reaction by the suspect; **and**
4. The suspect refuses to submit to a lawful arrest.

Note: Not all suspects who refuse to surrender are considered barricaded suspects necessitating a SWAT response.

What is a Barricaded Subject?

In addition to established protocols for a SWAT response, any of the following criteria may also activate a CNT only response for a barricaded subject depending on the incident's nature and imminent possibility of carrying out a suicidal threat:

- Armed persons threatening to commit suicide; or
- Suicidal person on an elevated platform or other unique venue that poses a significant safety risk to first responders

It is extremely important to understand that not all suicidal subjects are considered barricaded or require a SWAT/CNT response or immediate police action. There is a distinction between an armed barricaded suspect wanted for a crime, and a barricaded subject who has not committed a crime, but has expressed the desire to commit suicide. It is not a criminal act to express the desire or even attempt to commit suicide, and suicidal subjects or persons suffering from a possible mental illness are afforded the same level of legal protection as everyone else.

Requesting SWAT

Once the IC believes the incident meets the criteria for a barricaded suspect, the IC shall immediately contact Metropolitan Division's Watch Commander (WC) to request SWAT. The IC should be prepared to answer questions needed to determine if SWAT's response is warranted: who, what, why, when, where, and how.

Information about the suspect(s) should be gathered and communicated to the IC:

- Number of suspects
- Number of hostages
- Physical descriptors
- Clothing
- Ages
- Drug/Alcohol use
- Criminal history
- Mental state
- Floor plan of location
- Additional pertinent facts

Special Weapons and Tactics Team

Handling barricaded suspects is one of the SWAT team's specific assignments. The SWAT team has a dual role at the scene of a barricaded suspect. They gather information to provide tactical recommendations and/or solutions to the IC who maintains overall responsibility of the incident. The SWAT team will also develop and recommend a tactical plan to capture the barricaded suspect at the IC's request. Once SWAT has been assigned its mission, all tactically deployed personnel or first responders near the crisis site shall be guided by the direction of SWAT supervisors.

Crisis Negotiations Team

The SWAT team includes a Crisis Negotiations Team. The CNT component is comprised of SWAT officers and police psychologists from Behavioral Science Services (BSS) who are specially trained in crisis negotiations. Together, the team integrates tactical, verbal, and psychological knowledge and skills in order to negotiate the safe surrender of the barricaded suspect(s) and any victims who may be held against their will. In all instances, the CNT component will be deployed with any SWAT response.

Mental Evaluation Unit

When feasible and upon scene stabilization, any IC or officer who is in charge of an attempted suicide and/or barricaded suspect scene shall notify the Mental Evaluation

Unit (MEU), Detective Support and Vice Division, for advice. The MEU can help determine if any identified subjects have had previous contact with Department personnel. The Systemwide Mental Assessment Response Team (SMART) may be dispatched and able to assist in debriefing family members, witnesses, or other persons concerning issues related to the mental health of the involved person. The MEU personnel should not be used for tactical operations or other duties beyond establishing rapport with the subject, family members, or other persons who may provide crucial information that would help in resolving the situation peacefully. The MEU personnel may be relieved with IC approval.

Tactical Disengagement

Disengagement is the tactical decision to leave, delay contact, delay custody, or plan to make contact at a different time and under different circumstances. This tactic should be considered when an officer reasonably believes continued contact may result in unreasonable risk to the person in crisis, the public and/or Department members. Disengagement can be proposed by the primary unit, but requires consultation with the field supervisor at scene, the MEU Watch Commander (if the subject is experiencing a mental health crisis) and with Area watch commander approval.

The actions of first responders will be weighed against the information known and reasonably believed, governmental interest, subject's actions, and efforts to de-escalate the situation. Officers should continually assess the situation as circumstances change and new information is received. Tactical Disengagement is one of the tactics that may be considered when continued contact may result in an undue safety risk to the suspect/subject, the public, and/or officers.

Elevated Platforms

When a person has expressed the desire to harm themselves, avoid underestimating the danger or threat posed by the person's location. A person on an elevated platform may still be capable of causing serious injury or death to themselves or others, including first responders. First-responder actions should be limited to evacuating the area, establishing communication, and de-escalating the situation as much as possible.

Note: Los Angeles Fire Department (LAFD) personnel will most likely respond to these types of scenarios; however, it is important to understand that it remains a police-driven incident, and a unified command should be established to declare roles and responsibilities with LAFD personnel as soon as practicable.

Role of The Initial Communicator

Establishing communication with either the suspect/subject is essential. It is recommended that at least two officers be part of this crucial process. One officer establishes communication with the suspect/subject and the second officer relays information to the IC regarding progress of the incident. For optimum command and

control of the situation, supervisors should generally avoid becoming involved in the role of negotiator. Consideration should be given to de-escalating the scene without compromising safety. The following points are suggested for the initial communicator:

- Find out who, what, when, where, and why before making contact with the suspect/subject to determine their state of mind
- Do not jeopardize officer safety to approach or converse with the suspect/subject (i.e. give up cover, remove protective equipment, disarm or stand in a precarious position)
- Calm down before initiating communication. Attempt to stabilize and de-escalate the situation through dialogue
- Be prepared to remain as the primary communicator until relieved by the CNT

The initial conversation with the suspect/subject is extremely important. As an initial communicator, it is critical that verbiage is introduced that will temper and calm the situation. The following guidelines will assist the initial communicator in establishing productive dialogue:

- Introduce yourself by first name and as a representative of the Department; avoid use of rank or title
- If the suspect/subject does not give their name or refuses to respond, continue to communicate
- Allow the suspect/subject to vent
- Don't rush or interrogate– listen to the suspect/subject; remain calm
- Avoid a critical, uncaring tone or negative non-verbal communication (i.e. body language).
- Avoid rushing to problem-solve
- Build rapport and establish trust by using LEAPS – Listen, Empathize, Ask, Paraphrase, Summarize

General Negotiation Guidelines

The use of negotiations is another resource to control and manage the crisis situation. It is a process of combining verbal and physical tactics to affect the safe release of hostages or surrender of suspects/subjects. However, there are general guidelines that should be followed during the negotiation process:

- Avoid face-to-face negotiations when possible
- Avoid third-party negotiators until properly vetted
- Do not offer transportation or hostage exchange
- Demands for weapons, drugs or alcohol cannot be met
- Generally, suspects and hostages should not be allowed to go mobile
- Communicate in English whenever possible
- Discourage the use of cell phones by on-scene personnel, family members or friends whenever feasible
- Do not have the suspect/subject surrender until officers at the scene are prepared to receive them

- Avoid making promises that may/may not be feasible

Face-to-face negotiations are sometimes unavoidable; such as a “jumper” situation or an open area. However, it is imperative that the communicator stay a safe distance from the suspect/subject during negotiations (Distance + Cover = Time).

Grabbing/grappling with a suspect/subject on an elevated platform puts the contact officer at great risk, as well as nearby officers who may react instinctively.

Third-party negotiators are essentially individuals other than law enforcement personnel, typically family members, clergy, or friends. However, they need to be properly vetted before introduction to ensure that they will contribute to a peaceful outcome. Until the CNT relieves the initial communicator, it is recommended that a third-party negotiator not be introduced into the negotiation process unless it is unavoidable.

CONCLUSION

In incidents involving a barricaded suspect, the primary concerns are the preservation of human life, and the safety of the barricaded individual, first responders and the community. To ensure the safety of all involved, officers should consider tactics and techniques that may persuade the suspect to voluntarily comply or may mitigate the need to use a higher level of force to resolve the situation safely.

This Bulletin cancels and supersedes Volume XLV, Issue 4, Barricaded Suspects, dated December 2016.

Field Training Services Unit
Police Training and Education

DISTRIBUTION “A”



TRAINING BULLETIN

Los Angeles Police Department

Michel R. Moore, Chief of Police

Volume XLVIII, Issue 3

June 2019

EXCITED DELIRIUM

Excited Delirium, also referred to as Agitated Delirium, is a medical emergency characterized by an acute onset of extreme agitation and bizarre and/or combative behavior. This medical emergency is often associated with a number of underlying factors such as controlled substances, or mental illness. A person in a state of Excited Delirium is at an increased risk of sudden death.

Persons in a state of Excited Delirium may present a serious threat to the public, to officers, and to themselves. Officers should be familiar with signs and symptoms of this condition when determining the best tactical response. This Bulletin provides guidelines for addressing these challenges as part of the Department's overarching principle of reverence for human life.

Recognition of Signs/Symptoms

Officers are not trained to diagnose medical conditions but should become familiar with the signs, symptoms, and behaviors of a person in a state of Excited Delirium. The state of Excited Delirium is recognized as a medical emergency and a rescue ambulance (RA) shall be requested as soon as practicable.

Individuals in a state of Excited Delirium may exhibit extreme agitation and a combination of the following signs, symptoms, and behaviors:

- Extremely violent/aggressive behavior
- Unresponsiveness to police presence
- Excessive strength (out of proportion)
- High tolerance to pain
- Constant or near constant physical activity
- Attracted to bright lights/loud sounds
- Attracted to/destructive of glass/reflective objects
- Rapid breathing
- Profuse sweating
- Disrobing in public
- Keening (unintelligible animal-like noises)

When an individual exhibits signs of Excited Delirium, a Los Angeles Fire Department (LAFD) RA shall be requested as soon as practicable, so paramedic personnel can assess the individual and provide the needed emergency medical treatment.

Police Response

An individual acting in a violent and/or strange manner often results in police response. If the individual is exhibiting signs and symptoms of Excited Delirium, an RA shall be requested as soon as practicable.

Any officer faced with an individual who appears to be in a state of Excited Delirium should, if feasible, develop a tactical plan prior to taking action. The tactical plan should include a single contact officer, sufficient resources, and less lethal options.

Tactical De-Escalation Techniques

- Planning
- Assessment
- Time
- Redeployment and/or Containment
- Other Resources
- Lines of Communication

If the individual is contained and does not pose an immediate threat to officers, the public, or himself/herself, de-escalation techniques may allow officers the opportunity to communicate with the individual, refine tactical plans, and contact other resources as needed. When time permits, officers should obtain as much information as possible regarding the individual's past drug or alcohol use and mental health history before initiating action. Contact the Mental Evaluation Unit (MEU) if the person is suspected of suffering from a mental illness.

When attempting to verbalize with an individual who is in a state of Excited Delirium, minimize and/or remove lights, sirens, radios, and other distractions. Officers should utilize the "Contact and Cover Officer" concept. One officer should give clear and concise commands in a calm and non-confrontational manner. If the individual does not respond, officers should consider switching their contact and cover roles.

If the individual does not respond to tactical de-escalation techniques, officers should be prepared to use tactics to rapidly gain physical control. This will allow the individual to receive the needed emergency medical treatment.

Tactical Considerations

- Tactical de-escalation techniques
- Individuals in a state of Excited Delirium present a serious officer safety risk
- If feasible, avoid contact without additional resources present
- Have a tactical plan
- Consider less lethal options
- Avoid unnecessarily over-stimulating the individual
- Use a hobble to secure the legs
- Call an RA when Excited Delirium is suspected

Upon taking the individual into custody, officers should secure the individual's legs with a Hobble Restraint Device (hobble). Once the hobble is secure, officers shall place the individual in an upright, seated position or on his/her left side (left lateral recumbent position) as soon as tactically feasible. If this is not possible due to medical, tactical, or environmental issues, then the right side is an acceptable substitute.

If the individual continues to act violently or aggressively towards the officers, at least one officer should hold the person in an approved position while another officer maintains control of the hobble's strap. The hobble **shall not** be used to bind the individual's hands and feet together in any manner.

Medical Treatment

Excited Delirium is considered a medical crisis. When an individual exhibits signs, symptoms, and behaviors indicative of being in a state of Excited Delirium, an RA shall be requested as soon as practicable, so paramedic personnel can assess and treat the individual. In the request for the RA, include the signs, symptoms, and behaviors observed. Los Angeles Fire Department personnel have been trained in assessing individuals to determine whether a medical emergency exists and provide the needed emergency medical treatment.

CONCLUSION

Individuals who exhibit signs, symptoms, and behaviors indicative of being in a state of Excited Delirium may present a serious threat to the public, to officers, and to themselves. They are at risk for sudden death and need medical intervention. Officers should gather information and request sufficient resources as part of a tactical plan before contacting the individual.

Field Training Services Unit
Police Training and Education

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